1

16756

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16791

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: HELEN	Middle: JUNG	Last: AN	2a. DATE OF DEATH: Month Nov. Day 18, Year 1970	2b. HOUR: A M	
3. SEX: female	4. RACE: Korean (Parents)	5. DATE OF BIRTH: Aug. 8, 1970	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS 3 DAYS 10	IF UNDER 24 HRS.: HOURS MIN	
7a. BIRTHPLACE (State or foreign country): Kent Co. Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Kent Md.			
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kent & Queen Anne Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): none	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Kent	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET AND NUMBER: 526 High St.		
14. FATHER'S NAME First: Tai Sung	Middle:	Last: An	15. MOTHER'S MAIDEN NAME First: Sihn Ja	Middle:	Last: Lee	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: none	17. INFORMANT: Tai Sung An	Address: 526 High St. Chestertown, Md.	Father		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Tracheobronchitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
466X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure — 3 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11/17, 19 70, to 11/18, 19 70, that (I) (we) last saw the deceased alive on 11/18 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED
C. Gottfried Baumann		11/18/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C. Gottfried Baumann	Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/18/70	Chester Cemetery	Chestertown, Kent Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Wilkins Wells	Chestertown, Md	NOV 23 1970	Vernon R. Randall

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Item#5, FilmG430 11/9/70 kam

16757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16792

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
Gary	F.	Barrick	X	11	2	1970	2:30a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
male	White	9/6/70 1938	32 YRS.			11 / 2 / 1970	2:30 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Pa.	USA	MARRIED X	KENT Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural Still Pond	Still Pond, Md.	Farmer owner	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Kent	Still Pond	YES / NO	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Miller	Barrick		Geraldine	Smith	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Yes	Geraldine S. Barrick	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shotgun wound of head and neck — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

965X

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX / NO

21a. EXTERNAL CAUSE WAS PRIMARY X / OR CONTRIBUTING / CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	approx XX 10:00 M. 11/1 1970	Subject was shot by unknown assailant

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK X	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	HOME		Still Pond	KENT	Md.

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Peter Lipkovic, M.D.
Associate Medical Examiner

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 11/2/70

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/5/70	West Lauren Hill Cem.	Bala Cynwyd, Mo. Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wills Wells	Chestertown, Md.	NOV 5 1970	Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ____. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

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16758

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	JAMES ERNEST CLARK	2a. DATE OF DEATH Month Day Year	Nov. 13, 1970
2b. HOUR	6:00 P M		
3. SEX	male	4. RACE	white
5. DATE OF BIRTH	Aug. 18, 1900	6. AGE (In years last birthday)	70 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Mass.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Kent Md.
10. CITY OR TOWN OF DEATH	Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Kent & Queen Anne Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Farm Manager	12b. KIND OF BUSINESS OR INDUSTRY	Farming
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Kent
13c. CITY OR TOWN	Chestertown	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET AND NUMBER	Foxley Manor		
14. FATHER'S NAME First / Middle / Last	George Clark	15. MOTHER'S MAIDEN NAME First / Middle / Last	Ada Not known
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	Yes	(If yes give war or dates of service)	WW II
16b. SOCIAL SECURITY NO.	218 16 8875	17. INFORMANT	Mrs. Eugenia Clark
Address	Chestertown, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Liver failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO, OR AS A CONSEQUENCE OF (b) Laennec Cirrhosis — 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Anemia & Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 11-13, 1970, to 11-13, 1970, that (I) (~~we~~) last saw the deceased alive on 11-13 19 70 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	Harry Paul Ross	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED 11/13/70
22d. PHYSICIAN'S NAME (Type)	HARRY PAUL ROSS	22e. ADDRESS	Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	11/16/70	
23c. NAME OF CEMETERY OR CREMATORY	Chester Cemetery	23d. LOCATION (City or Town) (County) (State)	Chestertown, Md.	
24. FUNERAL DIRECTOR	J. Willis Wells	ADDRESS	Chestertown, Md.	
25a. RECD BY REGISTRAR DATE	NOV 17 1970	25b. REGISTRAR'S SIGNATURE	Vernon R. Randall	

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16759 — 16794

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ / ESTIMATED ☐ Month	Day	Year	2b. HOUR
Titus		Copeland	Nov	10	1970	5 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	Negro	7-4-1923	47 YRS.			11	10	1970	6 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Wash. D.C.	U S A		Kent Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Millington	Rural	Laborer	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Wash. D.C.				708 12th St. N.E. Wash. D.C.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ransom		Copeland	Dinah		Lhomar

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	577-20-0613	VA Hos. Records	Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease & infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At hame, farm, street, factary, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I taak charge of the remains described obove, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Robert W. Farr M.D.

EXAMINER'S NAME (Type) ROBERT W. FARR

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, tawn, or caunty)

22b. DATE SIGNED 11/11/70

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/16/70	Gettysburg Nat.	Gettysburg, Adams Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edward Fellows & Son, Millington, Md.	NOV 17 1970	Thomas B. Randall,

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16760

16795

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8, and 3 to 5 may be retained for your files. Give Pages 1 and 2 with the State Department of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with PM3. Page

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last
George	J.	Fisher

2o. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
Nov.	27	1970	2 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.
Male	White	Sept. 22, 1914	56 YRS.				

2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Nov.	27	1970	3:35 P.M.

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Illinois	U.S.A.		Kent Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Georgetown	------	Consultant Manager	E.S.D.

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Kent	Georgetown	YES ☒ NO ☐	--------

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	J.	Fisher	Minnie		Traub

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes.	W.W.II	522-14-7133	Mrs. Elizabeth Fisher, Georgetown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 0

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21o. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22o. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE O.S. Gulbrandsen M.D.

EXAMINER'S NAME (Type) O.S. Gulbrandsen, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑ Acting

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 11-29-70

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 30, 1970	Shrewsbury Cemetery	Kennedyville Kent. Md.

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edward Fellows & Son, Millington, Md.	DEC 2 1970	Edmund O. Randall,

VR A15ME (5) 10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16761 — 16796

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FHR. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: FRANK	Middle: JOSEPH	Last: KUEHNE					2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐	Month Day Year: 11/19/70 19	2b. HOUR: P M
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 6/12/1921	6. AGE (In years last birthday): 49 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.			2c. DATE PRONOUNCED DEAD	Month Nov. Day 19, Year 1970 19	2d. HOUR: P M
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐						9. COUNTY OF DEATH: Kent		Md.
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Route 213 Harmony Corner	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Electrician	12b. KIND OF BUSINESS OR INDUSTRY: Armco Steel							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Balto.	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET AND NUMBER: 9134 Philadelphia Road						
14. FATHER'S NAME: First Frank J. Kuehne	Middle	Last	15. MOTHER'S MAIDEN NAME: First Ada Mohr	Middle	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 218 01 9281	17. INFORMANT: wife Catherine Kuehne	ADDRESS: 9134 Phila. Rd. Baltimore, Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CRUSHED CHEST — 0
DUE TO, OR AS A CONSEQUENCE OF (b): AUTO ACCIDENT — 0
DUE TO, OR AS A CONSEQUENCE OF (c):

8169
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HEAD INJURIES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐
—	—	

21a. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6 P.M. 11-19 19 70	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): AUTO STRUCK HOUSE
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): RT 213	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: HARMONY CORNER, KENT, MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Oskar Gulbrandsen M.D.
EXAMINER'S NAME (Type): Oskar Gulbrandsen
ADDRESS (Street, city, town, or county): Chestertown, Md.
ACTING - CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ DEPUTY MEDICAL EXAMINER ☑
22b. DATE SIGNED: 11/18/70
Kent County

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-23-70	Sacred Heart Cemetery	Dundalk Balto. Md.

24. FUNERAL DIRECTOR / ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lassahn Funeral Home 7401 Belair Rd. 21236	NOV 25 1970	Vernon B. Randall

VR A15ME (5) 10M REV. 1/68

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16762 16797

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: George	Middle:	Last: Martin	2a. DATE OF DEATH Month: 11 Day: 3 Year: 1970		2b. HOUR: M
3. SEX: Male	4. RACE: Colored	5. DATE OF BIRTH: 7/2/1881	6. AGE (In years last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Kent County		Md.
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kent & Queen Anne's Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Labor	12b. KIND OF BUSINESS OR INDUSTRY: Various		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Q.A.	13c. CITY OR TOWN: Millington	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER	
14. FATHER'S NAME First: Joseph	Middle:	Last: Martin	15. MOTHER'S MAIDEN NAME First: Hannah	Middle:	Last: Lee
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 227-68-7940	17. INFORMANT: Mrs. Viola Comegys	Address: Cambridge, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ca of bladder (by history) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive Heart Failure – Gastroenteritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-3, 19 70, to 11-3, 19 70, that (I) (we) last saw the deceased alive on 11-3 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Gottfried C. Baumann		☑	☐	☐	11/19/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Gottfried C. Baumann M.D.	Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	11/7/70	Bethel Cemetery	Golt	Kent	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
[illegible]	Chestertown, Md.	NOV 10 1970	Vernon R. Randall

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16763 — 16798

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Herbert E. REIFSCHNEIDER	2a. DATE OF DEATH Month Day Year	Nov. 28, 1970	2b. HOUR	3 A M
3. SEX	male	4. RACE	white	5. DATE OF BIRTH	Dec. 3, 1900
6. AGE (In years last birthday)	69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Balto. Co. Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. COUNTY OF DEATH	Kent Md.				
10. CITY OR TOWN OF DEATH	Rock Hall (Rural)	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	At Home (	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Retired Medical Doctor
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Kent	13c. CITY OR TOWN	Rock Hall
13d. INSIDE CITY LIMITS?	YES ☐ NO XX	13e. STREET AND NUMBER	Piney Neck		
14. FATHER'S NAME First / Middle / Last	John Reifschneider	15. MOTHER'S MAIDEN NAME First / Middle / Last	Agatha Mohrfeld		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	Yes	(If yes give war or dates of service)	WW 11	16b. SOCIAL SECURITY NO.	215 05 2131
17. INFORMANT	Mary L. Reifschneider	Address	Rock Hall Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct.
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)	
21d. INJURY OCCURRED While ☐ Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** that (I) (this hospital) attended the deceased from Nov. 28, 1970, to Nov. 28, 1970, that (I) (we) last saw the deceased alive on Nov. 1970, and thot in (my) (our) opinion deoth occurred on the dote and hour and from the causes stated obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	H. Calvin Kaufman	DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	11/28/1970
22d. PHYSICIAN'S NAME (Type)	H. Calvin Kaufman	22e. ADDRESS	Rock Hall, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)	
Burial	Dec. 1, 1970	St. Paul Cem.	near Rock Hall, Maryland	
24. FUNERAL DIRECTOR	J. Willis Wells	ADDRESS	Chestertown, Md.	25a. REC'D BY REGISTRAR DATE DEC 1 1970	25b. REGISTRAR'S SIGNATURE Vernon B. Randall

VR A15 (74)
45M - 1 '69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16764 — 16799

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year
Lelia	Estell	Taylor	November 2, 1970

2b. HOUR: 8:50 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	May 27, 1895	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Virginia	USA	WIDOWED [X]	Kent Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chestertown, Md.	Kent & Queen Anne Hosp.	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Delaware	Kent	Hartley	YES / NO	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Oscar		Faris	Gertrude		Quick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no		Yes	Mrs. Va. Melvin - Hartley, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary edema due to CHRONIC AND ACUTE

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial decompensation — 2 wks

DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D — years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES / NO [X]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 30, 1970, to Nov. 2, 1970, thot (I) (~~we~~) last saw the deceased olive on Nov. 2 1970, and thot in (my) (~~our~~) opinian deoth occurred on the date and hour and fram the couses stated above, (I) (~~we~~) (did) (~~did not~~) view the bady ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Harry P Ross MD		XX			11/2/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Harry P. Ross, M.D.	Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/4/70	Chester Cemetery	Chestertown, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wilbur Wells	Chestertown, Md.	NOV 5 1970	Vernon P. Randall

VR A15 (4) 25m-1/70

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
IDM - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

16765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16800

1. DECEASED-NAME (Type or Print)	First: Dwayne	Middle:	Last: Walker	2a. DATE KNOWN OF DEATH ESTIMATED ☐	Month: 11	Day: 1	Year: 1970	2b. HOUR: 9:00 AM
3. SEX: male	4. RACE: Negro	5. DATE OF BIRTH: 6/12/1970	6. AGE (In years last birthday): 5 mos YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 11 Day 1 Year 1970	2d. HOUR: (9:00 AM)
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: KENT Md.				
10. CITY OR TOWN OF DEATH: R.F.D Worton, Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): AT HOME Worton, Md.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: KENT.	13c. CITY OR TOWN: Worton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.F.D			
14. FATHER'S NAME First: LARRY	Middle:	Last: WALKER	15. MOTHER'S MAIDEN NAME First: ASEATH	Middle:	Last: Moody		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: NONE	17. INFORMANT: MRS. ASEATH WALKER	ADDRESS: Worton, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sudden death in infancy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

795X

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Peter Lipkovic, M.D.

Associate Medical Examiner

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county)

22b. **DATE SIGNED**: 11/2/70

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11/4/1970	UNION CEMETERY	R.F.D WORTON, KENT, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Kenneth Wolfe	Chestertown, Md.	NOV 4 1970	Vernon O. Randall

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16766

CERTIFICATE OF DEATH

16801

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Mary Emma		WARD	Nov. 18, 1970	7 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
female	white	9/18/1898	72 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Kent Co. Md.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Kent Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Rock Hall (Rural)	At Home Piney Neck	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Kent near	Rock Hall	YES [ ] NO [X]	Piney Neck Sec.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Charles Henry Hudson	Emma E. Crouch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	
no	216 14 9712	Wilson Ward - Rock Hall, Md.	Husband

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
492X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio vascular
DUE TO, OR AS A CONSEQUENCE OF (c) emphyzemia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept, 1953, to Nov. 18, 1970, that (I) (we) last saw the deceased alive on Nov. 18, 1970, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Norbert C. Nitsch MD		[X]	[ ]	[ ]	11/18/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Norbert C. Nitsch	Rock Hall, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/20/1970	Wesley Chapel Cem.	Rock Hall, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Willis Wells	Chestertown, Md.	NOV 20 1970	Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16767 — 16802

1. DECEASED-NAME (Type or print): First FRANK Middle S. Last WELCH

2a. DATE OF DEATH: Month Nov. Day 8, Year 1970

2b. HOUR: 8 P M

3. SEX: male

4. RACE: white

5. DATE OF BIRTH: Aug. 15, 1899

6. AGE (In years last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN

7a. BIRTHPLACE (State or foreign country): Queen Anne, Co. Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Kent Md.

10. CITY OR TOWN OF DEATH: Worton, Md.

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rural at home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer retired

12b. KIND OF BUSINESS OR INDUSTRY: owner

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Kent

13c. CITY OR TOWN: Worton

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET AND NUMBER: Rural

14. FATHER'S NAME First Franklin Middle Welch Last

15. MOTHER'S MAIDEN NAME First Rena Middle Briscoe Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 215 36 0063

17. INFORMANT Address: wife Mrs. Grace W. Welch - Worton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Several years

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO X

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work X

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this haspital) attended the deceased from 5/22, 1964, to 11/8, 1970, that (I) (we) last saw the deceased alive on 11/8/70 19___, and that in (my) (aur) opinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Robert W. Farr — DEGREE: ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 11/8/70

22d. PHYSICIAN'S NAME (Type): Robert W. Farr

22e. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11/11/70

23c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

23d. LOCATION (City or Town) (County) (State): Chestertown, Md.

24. FUNERAL DIRECTOR: H. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: NOV 13 1970

25b. REGISTRAR'S SIGNATURE: Vernon P. Randall

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